LONDON NORTH DENTAL CENTRE

850 Medway Park Drive, Suite 101, London, ON, N6G 5C6

☐ **H. S. Sandhu**, DDS, PhD., Cert. Perio
Periodontist

☐ **S. Gibbs,** DDS, FRCD(C)., Cert. Perio
Periodontist

☐ **A. Hasanee**, DDS, Pediatrics

☐ **O. Azami**, DDS, Limited to Oral Surgery

☐ **M. Ravindranath,** DDS, Limited to Endodontics

☐ **S.Pani,** BDS, MDS, FRCD(C), Pediatrics

Introducing: _____ ***Date of Birth:*** _____

Address: _____

Home Number: _____ ***Cell Number:*** _____

Parent/Guardian: _____ ***Email:*** _____

Reason for Referral: ***(please attach/email all relevant x-rays & perio charts)***

☐ Consultation: _____

☐ Treatment: _____

_____

Relevant History/Remarks: _____

_____

Insurance Information:

Policy Holder's Name: _____ D.O.B.: _____

Name of Insurance Company: _____ Group/Plan #: _____

I.D./Cert #: _____ Employer: _____

When treatment is complete, how would you like us to manage this patient?

☐ Refer back to your office ☐ Keep patient here until older ☐ Parent to decide

Referred By: _____ Date: _____

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